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ABSTRACT

This report of the Select Committee on California Children's School Readiness and Health, established in 2001, examines the relationship between the status of a child's health and its impact on school readiness and achievement. The report is intended to promote and facilitate continued dialogue, exploration, and research on student health and academic achievement, while putting forward a package of legislative initiatives. Information was collected through a case study of the relationship between absenteeism and academic performance in four low-performing schools. Findings of that study indicated that healthy children attended school more regularly. Additionally, 7 months of hearings and roundtables were held to gather input from parents, teachers, physicians, and others about issues, concerns, and best practices dealing with children's school success and health. Topics included dental health, nutrition, pediatric assessments, mental health, and access to health care. One theme dominating the hearings was the lack of a seamless system of health services and support programs. Mental health issues were also mentioned at every hearing. Based on the findings of the case study and hearings, this report presents recommendations in seven areas: (1) seamless services for children and families; (2) physical health; (3) dental care; (4) access to health care and coverage; (5) mental and emotional health; (6) early childhood assessments; and (7) nutrition. The report concludes with descriptions of three family-friendly models of service, the agenda for the hearings, and a list of resources. (Contains 24 endnotes.) (KB)

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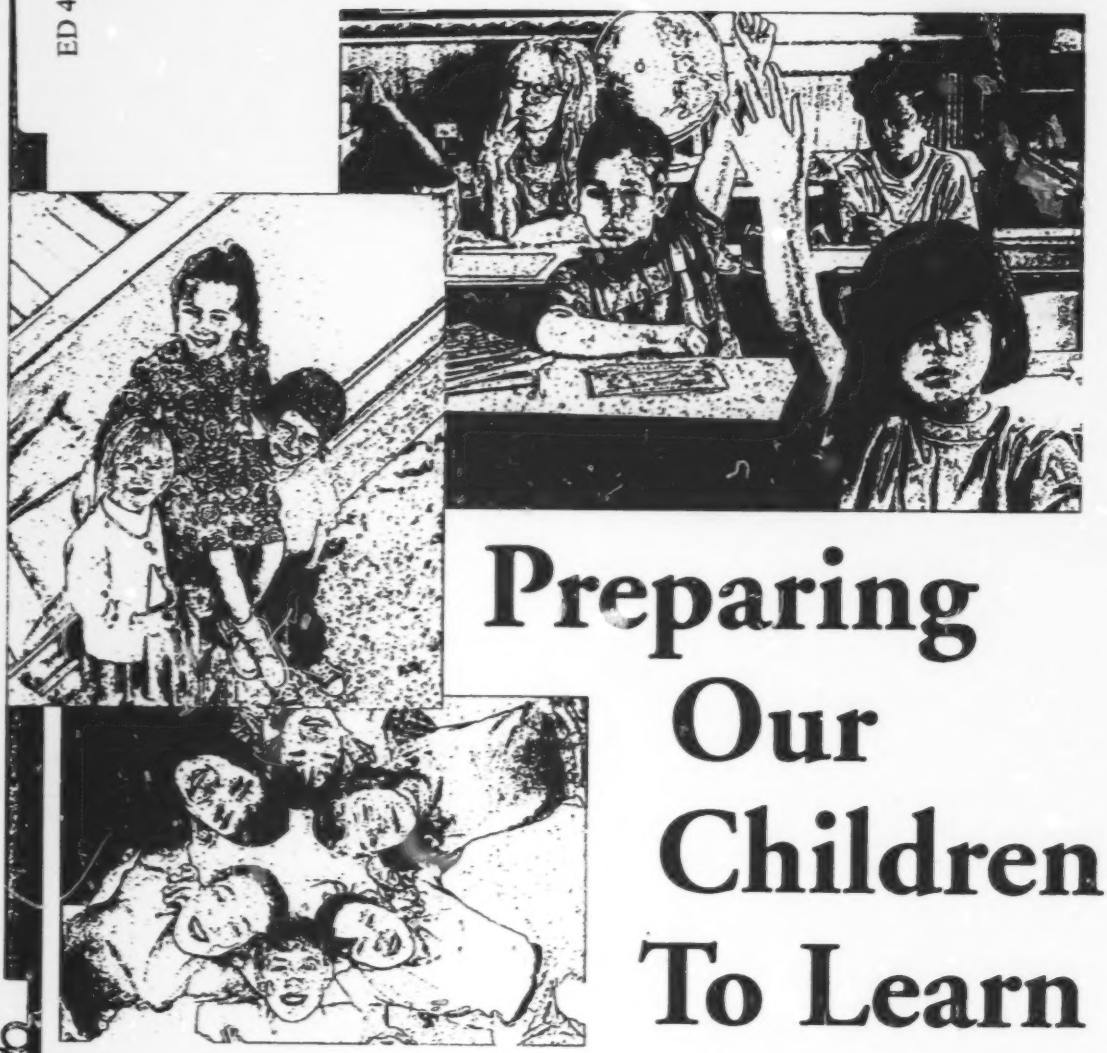

# Preparing Our Children To Learn

## Report of the Select Committee on California Children's School Readiness and Health

Assemblywoman Wilma Chan, Chair

March 2002

PS 030236

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## Purpose of the Select Committee

The Select Committee was established in 2001 to examine the relationship between the status of children's health and its impact on school readiness and achievement. The Select Committee works from the premise that a healthy child is more likely to come to school ready to learn and able to succeed in meeting the state's rigorous academic standards.

**You can't educate a child who isn't healthy and you can't keep a child healthy who isn't educated.**

(Dr. Jocelyn Elders, Former U.S. Surgeon General 1994)

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Finally, the Select Committee would like to express a very special thank you to each of our hearing participants and presenters. (A list of presenters can be found on page 27.)

# Introduction

**Academic success remains California's most important issue today.** In a December 2001 poll by the Public Policy Institute of California, education ranked almost equally with the economy and electricity as the top three issues facing California. Academic excellence, starting with the state's youngest children, is the priority for the Select Committee on California Children's School Readiness[1] and Health[2].

In 1999, Governor Gray Davis, in his first State of the State Address, made it clear that his **"first, second and third priority"** would be education. In later speeches Governor Davis reiterated his commitment to education and to what he called "The Era of Higher Expectations." Governor Davis explained that "The Era of Higher Expectations" had one overriding goal: improved student achievement.

In order to reach this goal, Governor Davis called the Legislature into a special session to deal with education legislation specifically focused on raising expectations for California's students. These legislative initiatives established academic benchmarks, some of which include: **by nine years of age every California child should read with confidence;**[3] by 8th grade students are expected to learn algebra,[4] and by high school graduation, students must pass a "rigorous" exit exam.

In fact, in this "Era of Higher Expectations," California has set some of the highest academic standards in the nation for its students. California made the "honor roll" in a landmark study done by the Fordham Foundation. This study, the "State of State Standards 2000," looked at the quality of each state's education standards and accountability systems[5]. California was one of only four states touted for its high academic standards.

## Purpose of the Select Committee

**The Select Committee was convened in 2001 to enhance California's ambitious academic agenda.** In particular, we charged ourselves with examining the impact of a child's health on his or her academic performance. While the state is to be commended for setting high educational standards for its students, many children will fail to meet these goals if they do not come to school healthy and ready to learn. For example, in 2002, one in five elementary schools in California ranked at the highest levels of the Academic Performance Index. While this is an increase from previous years, this represent only 20 percent of all elementary schools within the state.

**The findings and recommendations in the report not only reflect the hearings and research conducted by the Select Committee but also the work of countless individuals, organizations and agencies who have tirelessly advocated for children and the success of our public schools.**

### Salinas Hearing Testimony

**A parent detailed the difficulties she experienced in trying to obtain treatment for a child who was suffering from an eye infection. Because her family did not have health insurance she was unable to have her child seen by an appropriate physician. While the child's infection was initially treatable, because of the length of time it took to have the eye infection properly diagnosed and treated – by the time the child saw a doctor, she had lost vision in the infected eye and was forced to repeat one full year of school.**

While many factors contribute to school success, few studies have investigated both the physical and mental health factors associated with school readiness and early academic success. This report is intended to promote and facilitate continued dialogue, exploration and research on student health and academic achievement, while at the same time putting forward a package of legislative initiatives designed to make a substantive impact on children's lives.

**It is the intent of the Select Committee to work collaboratively with the administration, the Legislature, the California Department of Education, and all children's advocates in achieving the kind of academic excellence our state can be proud of.**

## Work of the Select Committee

**The Select Committee works from the premise that a healthy child is more likely to come to school ready to learn and able to succeed academically.** We began our work last spring by exploring the impact of poor student and family health on school attendance and the subsequent relationship of days missed on academic achievement. Initial data was collected through a study of the relationship between absenteeism and poor academic performance in four low performing schools.

**Children are born on a trajectory and for the rest of their lives a small change can have life long effects.**

**(Dr. Neal Kaufman, L.A. Hearing November 8)**

The committee followed this initial study with over seven months of hearings and roundtables across the state in Sacramento, Los Angeles, Salinas and Oakland. The Select Committee on California Children's School Readiness and Health has collected information and data that highlight the profound impact of health on school readiness and the ability to learn.

**California invests $43 billion from all funds in the education of 5.5 million pupils. And although schools are succeeding in some areas, too many children still enter high school without fundamental knowledge in English, math, science, and history. And too many young people will graduate high school without basic skills necessary to begin a college education or master the high paying jobs of tomorrow.**

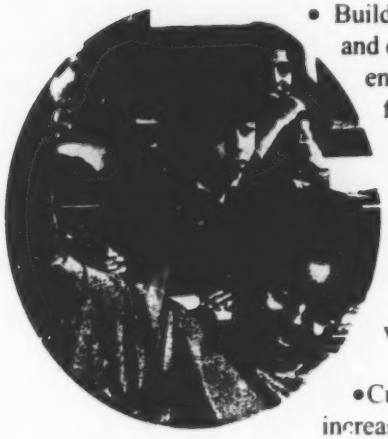
**(Governor Gray Davis, State of the State Address, Wednesday, January 6, 1999)**

Our mission was to hear and learn firsthand from parents, teachers, pediatricians, pediatric dentists, community service providers, school nurses, principals, school psychologists, health management organizations, school superintendents, and other children and family advocates about issues, concerns, ideas, and best practices dealing with children's school success and health. Topics of the hearings and roundtables included dental health, nutrition, collaboration and seamless family services, breastfeeding, pediatric assessments, mental health, and access to health care.

**The hearings brought many of California's best thinkers on children's issues together with people running innovative and effective local programs.**

**The key themes that emerged from the first hearings included the importance of:**

- Access to health care and utilization of health insurance.
- Early attention to the physical and mental health needs of children.



- Building on existing infrastructure to ensure a collaborative and cohesive approach to help children learn, including the environments where the majority of children ages zero to five spend their days – home and child care.
- Starting early in life to help children succeed.
- Parent training, involvement and family support.
- Appropriate training for professionals and staff who work with children and families.
- Culturally and linguistically appropriate programs for an increasingly diverse state.

Many of the statewide trends cited in this report were reflected in the testimony to the committee.

A number of other important, even urgent, issues emerged at the hearings, which due to time constraints, we were not able to address in depth. They include:

- Access to affordable quality child care
- Affordable family housing
- Pre-natal care
- Injury prevention
- Job training and employment for parents and caregivers
- Environmental health issues, including lead paint

These issues may be addressed in the next phase of the committee's work.

## General Findings

**One theme that dominated every hearing was the lack of a seamless system of health services and support programs.** There is a growing need for families to have access to seamless services, i.e. family resource centers – a one stop shop family health 'home,' where parents can go and receive whatever assistance is needed at the time, whether it is access to a pediatric dentist, help with early literacy or parent training.

**Up to 46% of kindergarten teachers reported that 1/2 of their class or more had specific problems in a number of areas in transition to school.**

**(Cox, M.J., Rimm-Kaufman, E.E., & Pianta, R.C.,(in press)Teachers' judgements of problems in the transition to kindergarten. Early Childhood Research Quarterly)**

**We found that in both rural and urban areas increasing numbers of children are entering school without the developmental foundation needed for academic success.**

**A recent study found that during the early years, the foundation of mental development is built upon the physical, social, and emotional environment of the infant and toddler.**[6] The experiences and relationships with adult and other children that the child develops during these early years directly impact neurological, cognitive, social-emotional, and physical development, which in turn influence school readiness and academic preparedness.

**We know that better academic, behavioral, and social success early in school increase the likelihood that children will later be productive citizens, measured by increased independence and social confidence, less reliance on social services, and higher earnings.**[7] Yet many teachers and parents told us that children often enter kindergarten without the skills and self-confidence to make the transition to formal schooling. In many cases, developmental, cognitive or emotional problems are not discovered until the child takes their 3rd grade standardized test.

**On January 24, 2002, First Lady Laura Bush made the case for early childhood education programs before the Senate Committee on Health, Education, Labor, and Pensions. Mrs. Bush explained the importance of providing pre-reading skills and better training for Head Start and day care workers, and she committed herself to helping "give our youngest Americans a real chance to succeed in the classroom."**

While there are many reasons why a child may not be prepared for school, participants noted disturbing statistics on the impact of a child's physical and emotional health on school success in the all important early years.

**For example, an estimated 51 million school hours per year are lost because of dental-related illness.**[8] More than half of children ages six to eight suffer from untreated dental disease. Yet dental screening is not required before a child enters school. Some of the barriers identified include a lack of pediatric dentists, low Denti-Cal reimbursement rates, lack of integration of dental health into general health assessments, and limited access to dental insurance.

**Many children struggle with vision problems, yet the state requires testing only for near sightedness.** Thus, other serious impairments may go undetected, leading to academic difficulties later in a student's life.

**Mental health issues were mentioned at every hearing.** The Surgeon General reports a conservative estimate that almost 21 percent of the nation's school children have a treatable mental health problem. Barriers to care include lack of parent education about mental health issues, perceived stigma, the complexity of obtaining state funds for services, and uncoordinated services. All children, not just those with identifiable mental health diagnosis, need positive social-emotional experiences in order to acquire the self-confidence and learning skills necessary for success in school. The basis for developing emotionally healthy children rests on appropriate and consistent relationships with parents and care-givers. The relationships can be weakened and disrupted by lack of parental support or education on the emotional needs of children, and by high turnover or poor training of child care staff.

**National Institute of Health studies indicate that students who are behind in reading in grade three have only a 12 to 20 percent chance of ever catching up.**

(English-Language Arts Content Standards for California Public Schools, Kindergarten Through Twelve)

**Lack of access to health care was also a recurring issue for younger and older children alike.** While California recently received a waiver from the federal government to cover parents under the Healthy Families – low cost health insurance plan, access to Healthy Families is limited to families whose income is at or below 250 percent of the Federal Income Guidelines, leaving many who cannot afford or are refused health insurance less able to care for the health of their families. Even for those with health coverage, utilization is often poor due to lack of information, cultural and linguistics issues or lack of physicians.

**Nutrition was another important issue that many speakers referred to during their testimony.** Studies have shown that nutritional deficits impact a student's concentration and ultimately can result in lower test scores. However, when students participate in food programs, such as the school breakfast program, students' test scores and attendance have shown marked improvement.[9]

**Fragmentation and discontinuity of children and family services was a major concern for many hearing participants.** At the state level in particular, services for children are scattered between dozens of programs, often with no coordination. The idea for a California Department of Children modeled after the California Department of Aging could be an innovative way to bring together education, health, and social services for children. This department would be charged with creating and sustaining a system of uniform services to children and their families.

We also learned more about local model programs that make the connection between health, school readiness, and achievement and from which we can draw ideas for state policy initiatives. They include the Elizabeth Learning Center in Cudahy and the Hope Street Family Center in Los Angeles.

The hearings served to showcase a number of statewide programs that could be used to provide a broader infrastructure for children's services aimed at school readiness. They include the Women, Infants and Children (WIC) program, which currently provides food and nutritional services to 1.2 million participants at 650 local sites throughout the state. Head Start is another example of a program with a solid record of success. There are 1,945 Head Start Centers, housing 5,081 classes – serving 102,075 low-income young children and their families.[10]

**By working together, elementary teachers, Head Start and preschool teachers, and parents can make starting school a positive experience for all.**

**(Continuity for Children, Positive Transition to Elementary School, California Department of Education, Sacramento, 1997 pg v.)**

The comprehensive types of services provided by Head Start can be incorporated into child care programs that serve working parents. Low and middle income parents who depend on full day, full year child care programs to maintain economic self sufficiency also need efficient access to health and parenting services that promote school readiness.

## Health, Absenteeism and Academic Achievement: A Case Study by Gary Yee, Ed.D. July 2001.

Dr. Gary Yee explored the relationship between the rate of 3rd grade students' absenteeism and their academic performance in four schools in Oakland and one school in Alameda, California. What he found was that students' absenteeism rates appear to have a direct correlation to their academic performance, especially in low performing schools. "Healthy children attend school more regularly; they are not distracted by chronic pain, physical discomfort, depression, hunger or anxiety; they come to school regularly and ready to learn. For public schools, where attendance is compulsory, there is a second assumption that frequent absences will affect achievement. Erratic attendance and frequent absences interfere with and disrupt the regular education program." (page two)

## Prospectus

The question we must ask ourselves is - if we know what children need to be successful in achieving California's academic goals and standards - what can we do as legislators, advocates, parents, medical and mental health personnel, community based organizations, and government agencies to make sure our children succeed?

California should begin its investment in children as early as possible. The state should become a leader in innovative policy and practice setting high health standards for our children which will help students achieve high academic goals.

Each of us must do our part to ensure the successful development of the state's greatest resource – it's children. **In order to ensure the future prosperity and success of the state, California must prioritize its investments to reflect the fact that children are our number one resource and asset. To do less would jeopardize the economic stability of our state and the quality of life we have come to expect.**

**Let us resolve that we shall do for our children what our parents did for us– provide them with the tools to fulfill their dreams. Guided by the example of those who preceded us, let us recognize that – except for securing our own freedom – there is no job more important than educating our children. It is the obligation of our generation and the best hope of the next.**

(Governor Gray Davis, State of the State Address, Wednesday, January 5, 2000)

## Agenda for Action

**The Select Committee on California Children's School Readiness and Health puts forth the following recommendations in an effort to guide California policy makers and implementers in a direction that is most beneficial to our children's health and academic achievement.** These recommendations cover seven specific areas: Seamless Services for Children and Families; Physical Health; Dental Health; Improving Access to Health Care and Coverage; Mental and Emotional Health; Early Childhood Assessments; and Nutrition.

**Children should receive the nutrition, physical activity and health care they need to arrive at school with healthy minds and bodies and to maintain mental alertness.**

**Child Trends, Final Report to the Knight Foundation, Background for Community-Level Work on School Readiness: A Review of Definitions, Assessments, and Investment Strategies, M. Zaslow, J. Calkins, T. Halle, J. Zaff, N. Geyelin Margie, December 2000 (page vi)**

The Select Committee is aware that there are many good ideas and suggestions on how to improve a child's health status and school readiness and that legislators have already implemented some excellent approaches in the past. **The recommendations found here are a starting point to approach school readiness and health in a broad public policy framework.** Further research, study, and collection of data will need to occur in order to answer more of the questions raised around the issue of health and its impact on student achievement.

It is important to note that while some of the recommendations suggested in this report will require an increase in state expenditures, others simply require a realigning of priorities and administrative regulations in order to realize improved health and educational outcomes for the state's youngest residents.

Finally, due to the overwhelming response to the Select Committee's call for information and material on the subject of children's school readiness and health, a supplemental book has been developed which includes further recommendations and resource documentation.

# I. Seamless Services For Children and Families

Across the state, in hearing after hearing, the Select Committee heard testimony about the difficulties families face when attempting to access educational, health care and other children's services. Local service providers also commented about the difficulties created by the lack of flexible funding streams and the fragmentation of various state agencies. While common sense tells us that preparation for school success includes a coordination among parents, schools, health care providers, child care systems and others, the state has not moved quickly enough to bridge the chasm between education, social services, and health care even within its own agencies. Professionals in these areas rarely engage in strategic alliances to address a child's school performance. Yet research has indicated that coordinated services for children and families have a positive impact on student achievement.[11]

## Recommendations

1. **Establish a California Department of Children's Services.** This Department should be modeled after the Department of Aging, to better coordinate health services and education for children and their families.
2. **Allow for a more flexible and blended use of government funding.** This would enable better coordination of existing educational, health and social services.
3. **Develop "one-stop" family resource centers in accessible, community-friendly locations with a "no wrong door" policy.** Comprehensive, coordinated family support service programs or "family resource centers" offer a "one stop" home for young children and their families, many of whom face numerous challenges. [12] Irrespective of the nature of the problem faced by a family, the resource center is designed to provide assistance in resolving the matter.
4. **Create incentives and funding sources to utilize existing infrastructure to establish school and community-based family resource centers.** (e.g. utilize WIC sites as an entry point for a range of family support and early childhood education activities including literacy programs.) In addition, school-based health centers appear to be quite effective in meeting the educational and health care needs of students and their families. "School-based medical assessment of student failure offers the opportunity for a more "natural," longitudinal assessment of the child experiencing academic difficulties. School-based health clinics have proven effective in addressing a variety of children's medical needs including health education, primary, and acute care. The success of these clinics suggest that school-based medical assessments of children experiencing academic difficulties may be a feasible adjunct to existing school services."[13]
5. **Expand Head Start Programs and other programs that serve children under the age of five[14] to include comprehensive developmental services for three and four year olds, as well as education, health, mental health, nutrition services, and parent involvement programs.** For example, Head Start Centers could serve as excellent family resource centers. Studies on the benefits of Head Start Programs have shown significant school readiness outcomes and improvements for children up to 12 years of age. Other benefits identified with children who participate in Head Start Programs include reduced special education placements and lower high school dropout rates. One study showed that for every dollar invested in the Head Start Program, a return of $7.16 was made based upon future income levels and lower utilization rates of public services (e.g. special education, welfare, criminal justice) by Head Start Alumni.

## II. Physical Health

We face daunting challenges in achieving the goal of having every child start school healthy and ready to learn. Today's children face many conditions which are far from ideal. Many of the state's children begin their lives with preventable health risks, yet far too many do not have access to preventive care services. These same students are then expected to perform at grade level by age nine and ultimately pass an exit exam to graduate from high school. Without proper intervention and attention to their physical health needs, many students may face extreme challenges in meeting academic standards.

### Recommendations

1. **Commission further research and study into the relationship and impact of health on academic performance, beginning with the earliest ages (zero to eight).** "While there is often an assumption that student health status and academic achievement is 'inextricably intertwined' (Symons, et al: 1997), there is remarkably little formal research reported in either educational or health-related research journals that links student health to academic achievement." [15]
2. **Expand the scope of compulsory vision screening to include testing for all vision impairments.** Comprehensive vision screening is critically important to identifying visual impairments that may contribute to poor school performance. Presently, school based vision screenings only test for certain types of impairments, which means other significant vision problems could go undetected and therefore untreated.
3. **Require medical insurance providers who contract with the state (HMOs and Medi-Cal) to cover the cost of an expectant mother's pre-natal visit with a pediatrician.** The American Academy of Pediatrics recommends a pre-natal visit with a pediatrician for high risk or first time parents. This visit allows parents to receive vital information regarding the importance of bringing their baby into a healthy and safe living environment and prepares parents to monitor the developmental indicators they should look for once the child is born. In addition, expecting parents receive advice on the benefits of good nutrition and breast-feeding.

### Sacramento Hearing Testimony

**One high school Superintendent took 400 of those incoming students who were reading below grade level and did individualized assessments of their vision. The results of the tests showed that over 50 percent of the students were actually suffering from serious vision impairments. He cited comments made by students such as, "I knew I wasn't stupid. There was something wrong with me that I just couldn't figure out."**

# III. Dental Care

Dental disease has reached epidemic proportions in California and the nation. Untreated oral health problems interfere with a child's ability to do well in school. More than half of California children, ages six to eight, have untreated tooth decay. Some school districts in the state report that one-half of student absences have been attributed to dental problems.

## Recommendations

1. **Change Child Health and Disability Prevention Program (CHDP) guidelines to require automatic referral to a dentist by age one.** Dental decay can begin as early as a month or two after a child's first teeth have erupted. The Department of Health Services (DHS) should allow for direct access to dentists through the Children's Treatment Program, a program for low-income children who are not covered by Early and Periodic Screening Diagnosis and Treatment (EPSDT) services. Currently, children under age three must be referred to a dentist by a physician, and only in cases where obvious dental problems are evident. Statewide standards for the Children's Treatment Program within CHDP should also be developed so that all counties provide benefits with similar scope and frequency and use Denti-Cal levels of reimbursement at a minimum.
2. **Require dental exams upon entering pre-school and kindergarten.** 27 percent of pre-schoolers in California have untreated tooth decay and nine percent need urgent treatment. Early Childhood Carries (ECC), or "baby bottle tooth decay", affects one in seven preschoolers and nearly half of elementary school children.
3. **Expand dental care services to children without dental coverage.** Having dental insurance is the best predictor of whether a child sees a dentist, yet the California Oral Needs Assessment of Children found that 26 percent of preschoolers, 28 percent of elementary school children, and 44 percent of high school students have no dental insurance. Nationally, some 108 million Americans have no dental insurance- this is more than twice the number without medical insurance. Healthy Families should offer a 'dental only' option for families who get health insurance through an employer. Furthermore, when negotiating Medi-Cal managed care contracts, the state should require formal arrangements with BOTH medical and dental providers.
4. **Increase access to preventative dental care.** Require all dental insurance and managed care plans to provide coverage for sealants and other scientifically proven preventative measures. Only ten percent of eight year olds in the state receive sealants for their first permanent molars.
5. **Expand the California Children's Dental Disease Prevention Program, established by SB 111.** This is the only statewide dental program for children. In place since 1979, it services 315,000 statewide, 20 percent of the eligible. Eligibility is based primarily on the percentage of students who receive free lunch. Services include weekly fluoride rinse, plaque control, and classroom oral health education. Additional funding could add dental screenings, sealants, and services to preschool children. Only ten percent of participants are ages four and five.

# IV. Improving Access to Health Care and Coverage

## A. Simplification of Public Health Insurance Programs

The state of California has seen improvements in the area of access to health care and coverage, however more needs to be done. Complicated eligibility rules and procedures continue to hinder enrollment. Focus groups and surveys have found that families are less likely to apply if the application process is too cumbersome. Simplified eligibility rules not only can improve enrollment but mitigate unnecessary red tape and bureaucracy, improving administrative efficiency.

### Recommendations

1. **Eliminate Medi-Cal Asset Test for Families.** To determine eligibility, Medi-Cal families are required to report all assets including savings, stocks, cars, and jewelry. Medi-Cal children may still be found eligible in other child-only eligibility categories if the family has "excessive" assets (just over $3,000 for a family of three). However, the assets test still applies to children who are applying with their parents and pregnant women applying for full scope benefits. If a family does not follow through on the application because of complicated asset documentation, the process may or may not be completed to enroll at least the child.
2. **Eliminate Medi-Cal "100 hour" rule.** The 100-hour rule still exists for two parent families under Medi-Cal—whereby eligible families cannot work more than 100 hours per month regardless of eligible income levels, without losing their benefits.
3. **Streamline paper documentation.** Currently, for Medi-Cal and Healthy Families eligibility, families must submit documentation to verify income and assets (no asset test for Healthy Families). In addition, the Healthy Families Program also requires children (and parents when implemented) to submit birth certificates to verify citizenship. As a result, families may not complete enrollment either because they must return home to find documents, which are difficult to locate, or if documents are mailed separately, many assistors and families report that they are lost by Healthy Families. The state could eliminate documentation for initial enrollment and/or renewal that is not required by federal law (such as income and citizenship) and instead have families self certify with counties performing a sample audit (similar to sample tax audits).
4. **Additional sites for enrollment.** Community contact points such as the Children's Health and Disability Prevention (CHDP) or Women, Infants, and Children (WIC) Programs could also screen for Medi-Cal or Healthy Families eligibility and offer either express lane enrollment or a temporary enrollment until full determination is completed. This could build on the new Express Lane eligibility sites: school lunch and food stamp programs. In addition, using CHDP as a gateway to public insurance coverage would create savings at the state level by more efficiently drawing down federal funds (Medicaid and State Children's Health Insurance Program).
5. **Require counties to make mail-in Medi-Cal applications (MC-210) available for distribution by community-based organizations.** The development of a mail-in application has been helpful in maximizing Medi-Cal enrollment. However, a state Department of Health Services letter dated December 24, states that "Counties are not obligated to supply MC-210 forms to anyone other than individual applicants/recipients, their families or authorized representatives." Counties that do not elect to provide these forms to community-based organizations present an obstacle to effective community-based outreach.

6. **Allow counties to make Healthy Families determinations.** If an applicant is deemed ineligible for Medi-Cal, counties should be allowed to make a Healthy Families determination rather than forwarding the Medi-Cal application and Notice of Action of Medi-Cal ineligibility to the single point of entry. Counties should also be permitted to seek reimbursement for Healthy Families eligibility determinations.
7. **Centralize the Medi-Cal eligibility computer systems for uniform applicability and timely updates.** Currently, counties' computer eligibility systems vary widely. A work group of Healthy Families and Medi-Cal should be convened to work with the existing Statewide Automated Welfare System (SAWS) consortia to address issues of Medi-Cal eligibility rules and Healthy Families interfacing with SAWS. The work group would review and address the effectiveness and feasibility of a single uniform Medi-Cal eligibility system to interface with the SAWS.

## B. Retention and Utilization

The ultimate goal of a health insurance enrollment system should be continuity of coverage and access to care. However, if families are not able to navigate the health system (e.g. select a plan, choose a doctor, make an appointment) or fail to comply with rigorous eligibility requirements, they may not receive care. Allowing families to retain coverage is an integral part to ensuring meaningful coverage and care.

### Recommendations

1. **Expand use of outreach funding for "retention" efforts.** The state should allow outreach funding to be used for important retention strategies including tracking systems for community assistors, follow up with enrolled families to assist in complying with program rules, and navigating the managed care plan systems. In addition, funds are needed to educate current and prospective members about the value of insurance and the importance of utilizing primary health care services.
2. **Automatically enroll newborns in Medi-Cal or Healthy Families if their parents or other siblings are currently in the program.** Often, a baby is dropped from her/his mother's Medi-Cal coverage before her/his eligibility is established. Such discontinuity of coverage may jeopardize the health and well-being of the newborn.
3. **Eliminate the 6 month no-coverage penalty for non-payment of Healthy Families premium.** As an alternative, the state should institute a minimal administrative fee. Otherwise, children lose coverage and cannot return for six months if they do not pay a premium.
4. **Coordinate renewal dates between Healthy Families and Medi-Cal to facilitate the renewal process for families with children in both programs.** In addition, create a joint Healthy Families and Medi-Cal application for renewal. Currently, Healthy Families has a customized renewal form while Medi-Cal is currently developing its own simplified form.
5. **Require Medi-Cal to accept the financial eligibility calculations from Healthy Families for individuals' applications transferred to Medi-Cal.**

# V. Mental and Emotional Health

In 1999, the U.S. Surgeon General reported that "almost 21 percent of U.S. children ages nine to 17 had a diagnosable mental or addictive disorder associated with at least minimum impairment." His report stated further that "[c]hildhood is an important time to prevent mental disorders and to promote healthy development, because many adult mental disorders have related antecedent problems in childhood. Thus, it is logical to intervene early in children's lives before problems are established and become refractory. The field of prevention has now developed to the point that reduction of risk, prevention of onset, and early intervention are implementable. Scientific methodologies in prevention are increasingly sophisticated, and the results from high-quality research trials are as credible as those in other areas of biomedical and psychosocial science. There is a growing recognition that prevention does work; for example, improving parenting skills through training can substantially reduce antisocial behavior in children (Patterson et al., 1993).[16]"

## Recommendations

1. **Develop and expand comprehensive mental health programs**. These programs should treat maternal and child depression, work to alleviate family stress, and focus on the parent child relationship. Addressing current parental psychological problems may have immediate benefits for children. Focusing on the education and parenting quality of the caretaker appears to be an important part of any program, such as treating maternal depression or teaching the parent how to care for the physical and mental well-being of his or her child.
2. **Increase and expand home visitation programs.** Home visitation programs may be one of the most effective ways to improve the health and well being of children who are at risk. It has been reported that one of the most successful interventions for improving both maternal and child outcomes is the Nurse Home Visitation Program, designed by Dr. David Olds.
3. **Increase and improve quality of early care and education programs and support their work with the social-emotional needs of children and families.** Just as parents need to build positive communication and trust with their child(ren), early care and education staff need to understand and act on developing and maintaining healthy relationships with children as the foundation for children's cognitive development. Better training in the emotional needs of infants and young children and appropriate compensation to allow staff to continue working with children greatly improves the quality of care and thus heightens the child's ability to succeed in school.
4. **Increase funding for the Early Mental Health Intervention program (EMHI).** The goals of the EMHI are to enhance the social and emotional development of young students; increase the likelihood that students experiencing mild to moderate school adjustment difficulties will succeed in school; increase their personal competencies related to life success; and minimize the need for more intensive and costly services as they grow older. Programs funded through EMHI serve students identified as experiencing mild to moderate school adjustment difficulties and are not intended to serve students with more severe difficulties. It has been demonstrated that programs based on systematic early detection and screening, backed by prompt and effective intervention, can prevent later adjustment difficulties at great savings to individuals, schools, mental health programs, and the state.
5. **Encourage counties to develop a children's mental health plan to provide preventative and treatment services.** County mental health departments need to work collaboratively with school districts, the child care community, Children & Families Commissions, and county social service agencies to maximize claiming and funding opportunities to provide mental health services to all children.

# VI. Early Childhood Assessments

Increasingly, children enter school before either their parents or teachers have a comprehensive understanding of the child's developmental, cognitive, social, emotional, and physical needs. Thus, early childhood assessments are a critical component of a child's school readiness. Four specific purposes for assessing the readiness of young children are: 1 - To promote children's learning and development in order to shape instruction for individual children by identifying what they already know and what they need more help learning; 2 - To identify children who may need health or other special services (to determine whether or not follow-up testing is needed, not for diagnosis); 3 - To monitor trends and evaluate programs and services in order to inform aggregate decisions; and 4 - To assess academic achievement in order to hold individual students, teachers, and schools accountable for desired learning outcomes.

## Recommendations

1. **Encourage child care centers to perform simple health and developmental assessments of children entering their program.** Conducting pre-kindergarten surveys that assess health issues before children enter school would help ensure proper follow-up and case management of problems before a child starts kindergarten. In addition, this will allow families direction and referral to appropriate resources and services.
2. **Offer additional training for pre-school teachers in developmentally appropriate practices, early childhood education issues and assessments, and planned transition activities.** This is possible through the expansion of programs such as the Early Intervention for School Success (EISS), a nationally recognized model to help teachers determine primary children's unique level of development. The EISS program provides financing, teacher training, authentic assessment, parent programs, and instructional resources.
3. **Facilitate transition of pre-school children to kindergarten.** Research has identified a child's transition from early care and education programs to elementary school as an indicator of future academic progress. Children who experience difficulty in transitioning into elementary school are at a greater risk of academic failure than children who do not. A Ready Schools Resource Group, convened by the National Education Goals Panel, found that "contact with previous caregivers can facilitate planning for individual students, provide a sense of continuity for children and parents, and allow a better alignment of philosophy, expectations, and curriculum across institutions and community."[19]

# VII. Nutrition

Recent evidence shows that infancy, toddler years, and early childhood are perhaps the most important developmental stages for establishing healthy eating and exercise patterns. These patterns can provide optimal growth and cognitive development, and prevent a lifetime of obesity and nutrition related diseases. If children do not eat the appropriate nutrients or engage in physical activity during these early years, by the time they enter school, they may already show signs of cognitive impairment, be overweight or at risk for obesity, and have established eating patterns that result in a lifetime of insufficient intake of milk, fruits and vegetables, and key nutrients, like iron and calcium.

Approximately eight percent of all pre-school age children are overweight and one-third of overweight pre-school children remain overweight as adults. Increasingly, overweight and obese children are experiencing health risks previously thought of as adult medical issues, such as type 2 diabetes, high blood pressure and high cholesterol levels. Eating habits and exercise patterns for children are most often established during early childhood.

## Recommendations

1. **Increase the utilization of WIC and Food Stamps Programs.** WIC and Food Stamps programs have been shown to have a positive impact on increasing the intake of important nutrients in a child's diet. WIC was found to increase the intake of ten nutrients, while Food Stamps increased the intake of five nutrients.[20] Increasing the availability and use of these programs to income-eligible families seems to be an effective strategy for ensuring a good diet for infants and young children.[21] The importance of good nutrition cannot be overstated. In California, 14 percent of young children are anemic, and iron-deficiency anemia, one type of anemia, is seen in four to nine percent of all U.S. children one to four years of age. Iron-deficiency anemia is associated with long-term negative effects on brain development and function, thereby prohibiting a student from realizing their full academic potential.
2. **Encourage all eligible schools to apply for school breakfast programs.** A series of studies conducted in 1998 by Massachusetts General Hospital and Harvard Medical School found that "students who increased their school breakfast participation showed significantly larger gains in math grades, decreased rates of tardiness, absences and hyperactivity as well as decreased depression and anxiety than students whose school breakfast participation did not increase." However, the California Food Policy Advocates report that in California more than 400 schools, which are eligible for start up grants and school breakfast programs, have not yet applied for them.
3. **Encourage nutrition education classes starting in pre-school and going through secondary school, including a parent education component.** Poor diet and physical inactivity are the leading preventable causes of cancer[22] and the second actual cause of premature death, following tobacco use.[23] Nutrition education is an effective way of developing healthy eating patterns among students. For this reason, one of the U.S. Department of Health and Human Service's health promotion objectives is to increase the number of schools that provide nutrition education from preschool through twelfth grade.[24] Students involved in nutrition education have the opportunity to make healthy food and lifestyle choices. As a setting for nutrition education, schools are an excellent site because they reach almost all children and their nutrition programs offer opportunities to practice healthy eating habits.

## Conclusion

This concludes the recommendations of the Select Committee on California Children's School Readiness and Health. We are aware that not all of the above recommendations will be realized immediately. However, we hope that with the information provided here and by other child advocates, the state of California will continue to move in a consistent direction that recognizes the strong nexus between good health and school success. We believe these recommendations take major steps in this direction, and we are pleased to have had the opportunity to share this information with you.

***In closing, the Select Committee would like to thank all of the people who work tirelessly on a daily basis to ensure that children arrive in the world, at day care, or at the first day of school healthy in mind, body, and spirit. While we understand the formidable challenges this work presents we are optimistic that by working together we will achieve our goal of having all of California's children healthy and ready to learn by the first day of school and throughout their lives.***

## Family Friendly Models of Service

The Select Committee is aware that there are many outstanding examples of "family friendly models of service" across the state. Below we highlight three such programs identified as "family friendly models of service." These programs serve children and their parents in a wide variety of ways, yet all are focused on providing resources in the most user-friendly manner. Moreover, these programs provide services to families in community settings; whether they be the family's home, medical office, hospital and/or school.

***Oakland Ready to Learn*** *is committed to mobilizing community resources in order to strengthen the parent skills of Oakland residents. Oakland Ready to Learn focuses on improving literacy levels by strengthening the role of the parent as a child's primary teacher. Their program strategy is to enhance rather than duplicate existing programs in the community. These programs include: Enrollee Kits: provides Enrollee Kits to parents when their child is born, when their child is six months old, and at each of the child's birthdays through the age of five. These packets are keyed to each child's age and contain information about parenting and local parent resources, a children's book, a child's toy, and child safety and health items. Materials are designed to enhance the parenting skills of new parents. Literacy Promoting Program: models reading by individuals in clinic waiting rooms, trains pediatric clinicians in the importance of literacy and strategies to promote books, and provides developmentally and culturally appropriate books for pediatricians to give away at each well-child visit. All activities are designed to support parents in their efforts to help their children achieve literacy and development. (Oakland, CA)*

***The Family Resource Center at the Elizabeth Street Learning Center (EFR)*** *is noted for its efforts to restructure and integrate school and community resources to improve the lives of children and their families. The center is a pre-K through 12th grade Los Angeles Unified School District (LAUSD) school located in the city of Cudahy, serving over 3,000 students. Through key collaborative partnerships, EFR is working to achieve a true system of integrated services. EFR is rooted in localized collaborative decision making and accountability within the school community, particularly with respect to organization, management, staffing, budget, and curriculum and outreach activities. Children and parents need to be seen in context of their family life and community setting. EFR's services are brought to one place which is key for the children and families they serve. EFR has significantly improved the academic success of its students. They have a 47 percent passage rate on the high school exit exam, while neighboring schools have a 20 percent rate. In addition, upon graduating, over 90 percent of their students go on to college. (Cudahy, CA) )(Using Family Resource Centers to Support California's Young Children and Their Families, Bruce Waddell, Michael Shannon, Rhea Durr, MPH a publication of the UCLA Center for Healthier Children, Families, and Communities, August 2001, page 7)*

***The Hope Street Family Center****, located on the grounds of the California Hospital Medical Center, provides comprehensive child development and family support services for over 400 low-income, at-risk infants, children, and families. The center is part of a national effort to support young children and families by offering services that enhance children's educational, social-emotional, and physical development while also strengthening family stability and social and economic self-sufficiency. Hope Street psychologists, nurses, physicians, early childhood educators, and other professionals work in collaboration with a wide variety of community-based agencies, parents, and a broad-based community advisory board. Core services include case management, child development, health care, parent education/support/vocational training, and youth services. (Los Angeles, CA)(Using Family Resource Centers to Support California's Young Children and Their Families, Bruce Waddell, Michael Shannon, Rhea Durr, MPH a publication of the UCLA Center for Healthier Children, Families, and Communities, August 2001, page 9)*

# Select Committee Hearing Agendas
# Fall 2001

**Wednesday, August 1, 2001**
**State Capitol - Sacramento, CA**

Presenters:

- Dennis Chaconas, Superintendent of Schools, Oakland Unified School District
- Joe Coto, Superintendent of Schools, Eastside Union High School District (San Jose)
- David J. Kears, Agency Director, Alameda County Health Care Services Agency
- Irene Ibarra, CEO, Alameda Alliance for Health
- Colleen Johnson, Senior Legislative Planner and Acting Director of Policy and Planning, San Francisco Department of Public Health
- Robert Sillen, Executive Director, Santa Clara Valley Health and Hospital System
- Bob Brownstein, Policy Director, Working Partnerships USA
- Leona M. Butler, CEO, Santa Clara Family Health Plan

**Thursday, November 8, 2001**
**Culver City, CA**

Presenters:

- Dr. Neal Kaufman, Director Division of Academic Primary Care Pediatrics, Cedars-Sinai Medical Center. Vice Chair Los Angeles County Children and Families First - Prop 10 Commission.
- John DiCecco, Director, Los Angeles Unified School District (LAUSD) Integrated Student Health Partnerships
- Marleen Wong, Director, LAUSD Mental Health Services
- Mary View-Schneider, Co-Director of UCLA's Center for Healthier Children, Families and Communities
- Carol Valentine, Elizabeth Learning Center
- Dr. Wendy Slusser, Breast Feeding program UCLA
- Eloise Jenks, Public Health Foundation, Women, Infants and Children (WIC) Program:
- Dr. Jackie Kimbrough, Executive Director, The Children's Collective
- Dr. M. Lynn Yonekura, Director of Development, Family Support Programs,
  Hope St. Family Center
- Beth Osthimer, Senior Health Policy Attorney, VIDA Project

**Thursday, November 29, 2001**
**Salinas, CA**
Presenters:

- Jack Harpster, Ed.D. Executive Director, Tellus/Díganos
- Bonnie Gutierrez, R.N. Health Services Coordinator, Pajaro Valley Unified School District
- Julie Edgcomb, Director, Member & Provider Services Central Coast Alliance for Health
- Carole Singley, R.N., Coordinator Parent Education/Health and Safety, Salinas Adult School
- Terry Espinoza Baumgart, MSW, LCSW, Coordinator of School Linked Health and Human Services,
  Alisal Community Healthy Start program, Alisal Union School District
- Jean Miner, former Executive Director of Children's Services International and Mountain Valley Family and Child Development Center
- Dr. Ray Stewart, D.M.D., M.S., Dental Director, Appolonia Foundation Children's Oral Health Program
  and Mobile Dental Center

**Wednesday, December 5, 2001**
**Oakland, CA**
Presenters:

- Dr. Rene Wachtel, Pediatrician, Children's Hospital Oakland
- Dr. Herbert Schreier, Director of Child Psychiatry, Children's Hospital Oakland
- Lucy S. Crain, MD,MPH, UCSF Clinical Professor of Pediatrics & Commissioner, San Francisco Children & Families Commission
- Dr. Lynne Huffman, Department of Pediatrics, Stanford University
- Mary Claire Heffron, PhD, Clinical Psychologist, Children's Hospital Oakland
- Karla Sagramoso, PhD., Psychologist, Children's Hospital Oakland
- David Perry, DDS, Pediatric Dentist, President, California Society of Pediatric Dentists
- Jane A. Weintraub, DDS, MPH Lee Hysan Professor and Chair, Division of Oral Epidemiology and Dental Public Health Department of Preventive and Restorative Dental Sciences-University of California, San Francisco School of Dentistry
- Jared I. Fine, DDS, MPH, Dental Health Administrator, Office of Dental Health, Community Health Services Division, Alameda County Public Health Department
- Lynn Pilant, RDH, BF, Dental Program Manager, Contra Costa County

# Resources

## Contacts

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Website: www.cfpa.net

**National Education Goals Panel**
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Website: www.negp.gov

**The National Institute of Mental Health**
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Website: www.nimh.nih.gov/childhp/fdnconsb.htm

**California Dental Association**
1201 K Street Mall, 8th Floor — Phone: (800) 736-7071
Sacramento, CA 95814 — Fax: (916) 498-6182
Website: www.cdafoundation.org

**The Dental Health Foundation**
520 3rd Street, Suite 205 — Phone: (510) 663-3727
Oakland, CA 94607 — Fax: (510) 663-3733
Website: www.dentalhealthfoundation.org

## For further reference the following is a list of articles and publications which may be of interest:

### Seamless Services for Children and Families

***Using Family Resource Centers to Support California's Young Children and Their Families***, Bruce Waddell, Michael Shannon, Rhea Durr, MPH a publication of the UCLA Center for Healthier Children, Families, and Communities, August 2001

### Physical Health

***Yearbook 2000 - The State of America's Children***, Children's Defense Fund

### Dental Health

***The Oral Health of California's Children: A Neglected Epidemic, Selected Findings and Recommendations from the California Oral Health Needs Assessment of Children, 1993-1994*** - The Dental Health Foundation 1997

***The Oral Health of California's Children: Halting a Neglected Epidemic, Selected Recommendations from the Children's Dental Health Initiative Advisory Committee*** - The Dental Health Foundation 2000

***Early Childhood Dental Caries***, L. J. Platt, MD, MPH, M. C. Cabezas, DDS, MPH, Building Community Systems for Young Children, A Project of the UCLA Center for Healthier Children, Families and Communities, March 2000

### Improving Access to Health Care and Coverage

***Healthy Families: Family Health Insurance Through One Door***, Authors: Dawn Horner and Wendy Lazarus, The 100% Campaign, Insure the Unisured Project, March 2001

### Mental Health

***A Good Beginning, Sending America's Children to School With the Social and Emotional Competence They Need to Succeed***, A monograph prepared by Robin Peth-Pierce, M.P.A, based on two papers commissioned by The Child Mental Health Foundations and Agencies Network (FAN) (2000)

***Surgeon General's Report on Mental Health***, Department of Health and Human Services, December 1999 & ***The Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda***, Department of Health and Human Services, 2000

### Early Childhood Assessments

***Child Trends, Final Report to the Knight Foundation, Background for Community-Level Work on School Readiness: A Review of Definitions, Assessments, and Investment Strategies***, M. Zaslow, J. Calkins, T. Halle, J. Zaff, N. Geyelin Margie, December 2000

***From Neurons to Neighborhoods: The Science of Early Child Development.*** JP Shonkoff & DA Phillips, Ed.s (2000) National Research Council and Institute of Medicine. Washington, DC; National Academy Press

***Continuity for Children, Positive Transitions to Elementary School***, California Department of Education, Sacramento, (1997)

***MEDICAID, Stronger Efforts Needed to Ensure Children's Access to Health Screening Services,*** United States General Accounting Office, (July 2001)

### Nutrition

***A Special Report to the American Cancer Society, Are Californians Meeting ACS Nutrition Guidelines for Cancer Prevention? Findings from Three Statewide Surveys of Children, Teens and Adults,*** Public Health Institute, The California Endowment, American Cancer Society.

***California WIC and Proposition 10: Made for Each Other***, by Shannon Whaley, PhD, and Laurie True, MPH, Building Community Systems for Young Children, (April 2000)

### Other Resources

***School Readiness: Helping Communities Get Children Ready for School and Schools Ready for Children***, Child Trends Research Brief, October 2001, Second Printing

## Endnotes

[1] *For the purposes of this report the Select Committee refers to children's school readiness as it is defined by the National Education Goals Panel (NEGP). The NEGP has highlighted five dimensions of children's school readiness: physical well-being and motor development, social and emotional development, approaches to learning, language development, and cognition and general knowledge. For further reference please access their website at www.negp.gov.*

[2] *For the purposes of this report the term health includes: mental, physical, developmental and emotional.*

[3] *AB 2x - Governor's Website K-12 Education – Historic Session on School Reform*

[4] *State Budget Education Summary - Office of the Secretary for Education, Interim Secretary Susan K. Burr 2000-01 - page 8*

[5] *The Fordham Foundation assessed public schools in every state to determine whether they have high academic standards and whether those standards are matched with measures to hold schools accountable for improved academic performance.*

[6] *JP Shonkoff & DA Phillips, Ed.s (2000) From Neurons to Neighborhoods: The science of early child development. National Research Council and Institute of Medicine. Washington, DC: National Academy Press.*

[7] *Huffman, L.C., Mehlinger, S.L., & Kerivan, A.S. 2000 – Risk factors for academic and behavioral problems at the beginning of school. In A Good Beginning: Sending America's Children to School with the Social and Emotional Competence They Need to Succeed (monograph). Bethesda, MD: The Child Mental Health Foundations and Agencies Network.*

[8] *Gift HC. 1997. Oral Health outcomes research: Challenges and Opportunities. In Slade GD, ed. Measuring Oral Health and Quality of Life (pp. 25-46). Chapel Hill, NC: Department of Dental Ecology, University of North Carolina.*

[9] *The Bottom Line: California School Breakfast Affordability Study, California Food Policy Advocates*

[10] *California Head Start Association – California Head Start Facts, (2000-2001)*

[11] *Using Family Resource Centers to Support California's Young Children and Their Families, Bruce Waddell, Michael Shannon, Rhea Durr, MPH, A Publication of the UCLA Center for Healthier Children, Families, and Communities, August 2001*

[12] *Ibid.*

[13] *Journal of School Health, Sept 1996 v66 n7 (page 242)*

[14] *Head Start programs, while excellent models for comprehensive services, do not serve all working families who are often under great stress and also need comprehensive assistance. The majority of children in California – including those most at-risk of school failure – are served by the broader child care service delivery mechanisms – family child care, child care centers, and license exempt individuals. An effort to improve the quality of all child care/child development programs serving children under five in California is of great importance in improving the health and school readiness of our kids.*

[15] *Health, Absenteeism, and Academic Achievement: a Case Study, G. Yee, Ed.D. July 2001*

[16] *Report from the Surgeon General's Conference on Children's Mental Health: A National Action Agenda, Department of Health and Human Services, 2000*

[17] *Child Trends, Final Report to the Knight Foundation, Background for Community-Level Work on School Readiness: A Review of Definitions, Assessments, and Investment Strategies,, M. Zaslow, J. Calkins, T. Halle, J. Zaff, N. Geyelin Margie, December 2000 (page 41)*

[18] *Child Trends, Final Report to the Knight Foundation, Background for Community-Level Work on School Readiness: A Review of Definitions ,Assessments, & Investment Strategies, M. Zaslow, J. Calkins, T. Halle, J. Zaff, N. Geyelin Margie, December 2000 (p vi - vii)*

[19] *Ibid.*

[20] *(Rose, Habicht, & Devaney, 1998)*

[21] *Child Trends, Final Report to the Knight Foundation, Background for Community-Level Work on School Readiness: A Review of Definitions, Assessments, and Investment Strategies,, M. Zaslow, J. Calkins, T. Halle, J. Zaff, N. Geyelin Margie, December 2000 (page 25)*

[22] *Colditz GA, DeJong W, Emmons K, Hunter DJ, Mueller N, Sorenson G, eds. (1997). Harvard Report on Cancer Prevention. Vol. 2: Prevention of Human Cancer. Cancer Causes Control 1997; (8 suppl 1); s1-s50.*

[23] *McGinnis JM and Foege W (1993). Actual causes of death in the United States. JAMA, 270, (18), 2207-2212.*

[24] *ERIC Clearinghouse on Elementary And Early Childhood Education, Urbana, IL., ED369579, (1994)*

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